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ABSTRACT

The poor self-image of many collegiate high achievers is due to the development of an obsessive-compulsive personality. Typical of this psychological maladjustment is the concept that external achievements are directly related to internal personal worth in a linear and absolute fashion. Characteristic symptoms include physical as well as emotional complaints. Treatments a university health clinic can provide for students suffering from this syndrome are most effective when centered around a brief treatment approach. Based on a series of dialogue sessions, the student and the therapist work together to design an individualized treatment plan. The prime mechanism is a thorough examination of the student's previous psychosocial history coupled with analysis of present feelings and anxieties. Stress is placed on putting the student "in touch" with his/her own needs and desires. Treatment terminates with the student's realization of his/her own behavior patterns, motivational stimulus, and renewed sense of self-understanding. (LH)

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Thomas V. Foster

BRIEF TREATMENT OF THE SYMPTOMATIC OBSESSIVE-COMPULSIVE STYLE

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" ... the slowly passing quiet winters were accompanied by burning pain in his eyes and an aching head. He drank more coffee and took aspirin liberally, hoping to blot out the pain and be able to go on studying without discomfort.

... he usually studied until he could not remain awake any longer, and he'd drop into bed and into a heavy sleep of exhaustion.

After the bell of his ten o'clock class would ring... he would sag into a let down, and feel weariness, and with this, he'd become morose with depression and an emotional feeling of hopelessness which was the outgrowth of fatique."

James T. Farrell
The Silence of History

Our society places great value on productivity, achievement, and attainment. For better or for worse we are and have to be competitive if we are to function in much of our culture. A portion of our acculturation is designed to motivate us to expand our natural curiosity and our instinct for mastery in the service of social and economic competitiveness. Combining this push with the pyramidal nature of our organizations, with less and less room at the top as one climbs higher, produces

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an always present and sometimes intense pressure to perform.

Character traits which accentuate dependability, interest in advancement, perfection, loyalty, work over play, deference to authority, allegiance to social order are esteemed. They can be valuable in meeting social expectations, and in attaining personal goals. We recongize these traits commonly as obsessive-compulsive or compulsive. They are widespread, and often present in the successful and ambitious. It is no accident then, that persons with these kinds of personality descriptors are especially prevalent in colleges, universities, and professional schools.[1]

This personality style with or without other related character traits can be employed in the service of healthy adaptation or as is all too frequently the case, can be used to repair perceived deficiency or solve conflicts. It can be seen as only part of a personality style or in pure form as the dominant feature.[2]

Students somewhere on the obsessive-compulsive continuum routinely present themselves for help. They come either because of the dysophoric nature of their style or more commonly because it is associated with other symptoms, the most usual is agitated depression.

Planned and unplanned brief treatment is something familiar to most professionals working in college health clinics, and for a number of reasons wider interest in short term treatment has become increasingly evident. First is the usual inquisitive, intellectual pursuit of new information or better ways. This line of organized investigation can be traced at least back to

Ferenzi and Alexander in the psychoanalytic school. More recently pressures for expanding services, increased demand for the public, and increasing monetary restrictions have added to the attention brief treatment has received.[3,4]

Most of what has been written, except perhaps in the behavioral literature, has been in a general context, exploring such perameters as time limits, frequency of sessions, intervals between sessions, etc. With the exception of depression, not much seems to have been done to match a specific category or dysfunction, or syndrome, with a specific brief treatment.

The purpose of this paper is to discuss a particular approach to the short term work with a subset of individuals with obsessive-compuslive personality style who are symptomatic. They have been students who have met the compulsive personality and/or obsessive-compulsive disorder criteria of DSM III. In addition they have severe subjective poor self-esteem/self-image, even when not dysfunctional or seriously distressed. The treatment approach is essentially a time limited, focused psychotherapy. To help illustrate my remarks I would like to present and follow two representative cases.

CASE I
PART I

George, a 20 year old sophomore, liberal arts, pre-med major came to the clinic with a two month history of anxiety episodes and depression. He felt as if he was going to "fall apart, go insane", decompensate; he also had feelings of pressure in his head, numbness, and a "spaced out" sensation.

George reported feeling "down", sometimes hopeless and helpless and had thoughts of suicide, but without plans or attempts. He had had other periods of similar thoughts and feelings in the past which would last several weeks and gradually dissipate if he withdrew from the activity associated with the symptoms he was experiencing.

George had an essentially negative medical and psychiatric history. He felt that it was important to do well in college, and had fantasies about how he would be looked up to and respected if he could be a doctor. Men would admire him, women would desire him. It was, however, important not to be caught unprepared. Everything had to be done to its absolute best.

He had to read Time, Newsweek, two major daily papers, and watch the CBS Evening News lest he be thought not up on current events. He believed that he was socially, and somehow inherently, inferior to most of the other students whom he respected or admired. He often experienced envy, jealousy, hostility and sadness as feeling states. He had recurring thoughts which he couldn't get rid of; they were like broken records that would play over and over. Had he tried hard enough on that paper?

Had he checked his work carefully enough? Should he study more? Had he remembered to check his lab equipment? Had he said something to offend that girl? Did she think him oafish? He couldn't be spontaneous, he had to think it over first.

His present distress had started after he had come back from a pleasant, relaxed summer vacation and started the "grind" again.

CASE II
PART I

Ted is a 22 year old business major, one quarter from graduation. He works a substantial amount of time as a salesman at a local retail store. He came referred by a student health service physician for consultation and evaluation.

Ted reported that his primary difficulty was feelings of "imminent doom". This took the form of feeling that he was going to lose control of himself, that he would do or say things he didn't want to do or say. He wasn't exactly sure what would happen although he had the vague notion that it would be destructive.

This had all begun about three months before when he had been accidentally hit in the head with a softball while walking down the hall in his dorm. He was momentarily stunned and had some localized pain. Shortly thereafter, he began to experience excruciating headaches. An evaluation demonstrated no pathology.

Subsequently, his headaches went away and were replaced by

dizziness and lightheadedness and the ominous, but vague feeling of dread which had continued up to the time of consultation.

Ted was again evaluated, first by a health center general physician and subsequently at a medical teaching center. The work-up included, an EEG, CAT, SCAN, LP and other neurological and physical assessments, all of which were within normal limits. Ted seemed to be temporarily relieved by this and for awhile he felt that there was nothing physically wrong with him. However, the subjective complaints quickly returned. At this point consultation was offered.

Among other things reported by Ted in our first hour was that just prior to the accident, he had been promoted to a new position in the department store where he worked full time while also going to school with a full academic load in the honors program, and maintaining a 3.8 out of 4.0 cumulative average. He also was contemplating marriage, but couldn't decide whether or not to go ahead with it; he was applying both to law school and to graduate school and had been offered a lucrative position with the store following graduation. He seemed to feel that this amount of activity was nothing unusual.

Ted's thought content and affect were marked by intense ambivalence regarding all the decisions facing him. He felt that is was important not to make a mistake in his choices. How could he be sure that his girlfriend was the right girl; that his company was the right company? Was law school better

for him than graduate school or was taking the job the correct and best thing to do? If only someone or something could tell him. He was afraid he wouldn't get accepted to any post-graduate programs; he wasn't good enough, he probably hadn't done enough. He reported routinely working at least 16 hours a day at school, his job and exercising. He allowed himself Saturday night for fun.

FRAME OF REFERENCE

It had been my experience that a number of students can be understood by examining their self-system. This concept borrows a Sullivanian term and adds to it both my observations of patients and information from recent interest and investigation of the parameters and factors involved in self-esteem and self-image.[5,6,7] Central to my frame of reference relative to obsessive-compulsive personality organization is what Salzman calls the pursuit of perfection. On some level most people with obsessive-compulsive traits can be seen as engaging in this relentless pursuit of perfection.[8] Directly connected to this activity, in my experience, is the maintenance of the self-system, and especially self-esteem. Like the hub of a wheel with the spokes radiating from it, sits the symptomatic student's self-esteem/self-image. All the characteristic defensive maneuvers, behaviors, adaptative attempts, cognitive processes radiate out from it and can be traced back to it. They in turn are interconnected and mutually supportive.

Although each patient's developmental history is unique, each somehow seems to have established a connection in his/her mind between his/her esteem of his/her self and how he/she performs. They become more externally oriented. They do not trust their internal feedback because they all too often believe it is inaccurate and a product of inferior equipment.

The other important developmental process, arrived at by many paths, is a very poor self-image. Somehow they have come to see themselves as defective, missing something not totally there. This can take many forms. The students may believe that they are below average in appearance, in intellectual endowment, in social grace, or in physical abilities. Finally, they have gravitated to a life of the mind, manifested by a detachment of feelings from thoughts, a heightened emphasis on mental functioning and academic/intellectual success.

The connection between self-esteem and accomplishment is, of course, inherent in the human condition. It is the difference in quanitity and quality which distinguishes between the universal experience of self-doubts, uncertainty, pride in achievement, self-esteem holstering by excelling, and the obsessive-compulsive's constant gnawing sense of inferiority, and almost desperate need to do better, or be best.

This is to say that there is an average expectable amount of self-questioning and esteem modulation. In those with self-system problems it is excessive, autonomous and not greatly influenced by reality or real success. Inside these people there is missing a solid sense of competence; that is

they do not have a core feeling that they can at least do somethings well and that they can rely on themselves to provide for many of their own intake needs. Associated with this deficiency is a lack of self-confidence. How can one be somewhat confident if the self-perception is that of someone who is incompetent? This is secret knowledge that has been kept from others by hard work and constant surveillance. The fear of fears is that something will slip and the outside world will see the person for what he or she thinks, he or she is incompetent and defective and therefore unlovable and undesireable.

INTERVENTIONS: Methods and Principles

ASSESSMENT

Following usual clinical practice, the first step of intervention is an assessment of the presenting problem and the factors contributing to it. This process is divided into two parts, general and specific. The general assessment is the usual comprehensive, psychological/psychiatric evaluation, the purpose of which is to ascertain the pertinent, positive and negative features of the student's situation. Covered are the biological, social, psychological, cultural and environmental influences which bear on the student's general functioning and the specific problem for which he/she present his/herself. As is usual the assessment bears on the possible treatments from which one can select. The goal of the general assessment is to eliminate anything which would require treatments other than the brief therapy techniques to

be discussed below or for which specific focused techniques are contraindicated. Once it has been reasonably ascertained that the primary difficulty is the student's habitual, characteristic style and that it is predominately obsessive-compulsive with its usual symptomatology and adaptive mechanisms; and that, in quantity and quality, it is outside normal limits, then the student becomes a possible candidate for brief treatment.

The second part of the assessment is that which is specific for the brief treatment; namely that the level of dysfunction and the amount of those areas of personality function which are intact are such that there is a high likelihood that signficant progress can be made within the context of a time limited treatment. It is important that the dysfunction not be so great as to need long contact or removal from the present environment, either in the form of hospitalization or temporary withdrawl from school. The students are selected if it seems likely that the specific difficulty which brought them in can be resolved in 6-8 sessions, at a frequency of once a week. For the techniques to be appropriate it is important that there clearly be major problems in the student's self-esteem, self-image, and that these deficiencies or difficulties are directly connected to their functioning and their symptoms. It is important that these self-perceptions be somewhat conscious to the individuals, that is, that they can readily acknowledge that they have a perception of themselves as injured and deficient. It is also assumed that the usual criteria for psychotherapy can be met, that is the student is motivated, is able to form a reasonable therapeutic alliance, is open and cooperative, is verbal and understands and agrees to the intent of the treatment.

TREATMENT CONTRACT

After the general and specific assessment is completed, the next step is the discussion with the student of the therapist's assessment of the nature of the difficulty. This occurs in a hierarchical way. One starts with the specific incident, if there is one which has brought the student to the clinic next moving to the general behaviors which characterize the student and then to the self-system and self-perceptions that exist. Finally, the tentative hypothesis that these may all be connected and interrelated and may be an explanation of what the student is experiencing is presented. The therapist then outlines the possible interventions he or she thinks would apply. This will differ according to the situation and circumstances of the clinic, the ancillary help-giving agencies available, and student's financial and emotional resources. What the therapist is willing to do is offered; to meet on a once a week basis for 6-8 times, to focus on the recognizing behaviors, and attitudes, trace their history, to understand how they may fit together and to examine the consequences which flow from them. Then finally to try to discover other options which may be available to the student. The student is then given the opportunity to ask questions and to negotiate and offer other possibilities or to modify the contract in anyway he/she might deem more desireable. After the therapist and the student have agreed upon the exact way they will proceed, the student then makes standing appointments for 6-8 sessions such that they have specific times and dates outlined for them and can see the beginning and end of the

treatment process. The time limit and contract are adapted from James Mann's approach.[9]

GOALS AND STRATEGIES

Once the contract has been made the actual intervention process begins. Its composition includes: an examination of the cognitive processes, connecting thoughts and feelings; examining the consequences of the style and characteristic adaptive operations in their entirety. The process is carried on within an atmosphere of inquiry; with the attitude that one is testing hypotheses. The student and therapist are examining the factors which operate, and why it might be that they exist as they do and what the consequences are to the student. These goals are arrived at through use of the therapeutic alliance between the therapist and student in which both are attempting to first recognize what is going on and what is routinely happening and secondly to understand it if possible; then to examine how and why aspects connect together and to understand how it might have gotten to be this way. Finally and often the most difficult step, is to explore and implement self-redirection if this is desired by the student.

Usually it readily becomes clear that the student's characteristic cognitive processes have a predictability charactered among other things by a difficulty in tolerating ambiquity. Events and circumstances are seen in absolute terms, they are either black or white, right or wrong, on or off. There is very little middle ground, or gray zone and if there is any at all, it is usually associated with the

experience of anxiety and a queezy unsettled feeling that is only remedied by finding an answer in some absolute direction. This tends to polarize the choices and polarize the feeling states thereby complicating the decision-making process. Combined with this is an ambivalence dominated consciousness. Everything has pros and cons to it, there are always two sides to the coin and there never is the certainty, which is so desperately wanted that ones choices are correct or that ones position is irrefutable and without flaw. Because of this ambivalence, there is a constant waffling back and forth on any course of action involving all but the simplest choices. All alternatives are seen as equal. They all have merit and value but the individual's job is to pick the correct, "perfect" choice. There is a lack of confidence in the accuracy of the student's own perceptions such that the student is never certain when his choice and his reasons for making it are really valid. There is a great deal of difficulty in making priorities and seeing the limit of the individual's abilities and delegating work or responsibilities to others.

The examination of these cognitive processes which are often present begins by a dialogue, usually centered around a decision the student is trying to make or around thoughts he/she has about his/her present circumstances. In the discussion of the present problems and the present situation these processes become quite apparent. They are laid out on the table, so to speak, for examination. One then begins looking at the consequences of thinking this way and asking

the question of how they could have become the characteristic thought processes; from whence did they come and what purpose do they serve? This usually then leads into a discussion of the need to not make mistakes, the need to be certain and the need to have control, which connects to and is motivated by the pursuit of perfection. This in turn leads to the reason one has to be perfect which is usually because if you are discovered making mistakes you'll be seen as less than you want to be or less than you think you ought to be. The principle goal here is to demonstrate what the processes are because the student has never thought or realized that other people often do not think the way they do. They frequently have not experienced someone else offering other possible interpretations, namely that there may be situations in which there is no right or wrong answer, but in which things are more relative and that there is an awful lot of gray in everything we do.

Next is the examination of the consequences of this cognitive style. The student usually begins to see how thinking this way restricts choices and makes them somewhat rigid, unbending, and makes it difficult for them to compromise which in turn has a direct influence on their relationship with other people. It also helps them see how their self-esteem is at the mercy of these processes. One is almost put in a position where you can never succeed enough to satisfy yourself. Once the individual recognizes that they are driven, then the question again is why and how did this come to be?

Some of the purposes and goals of his/her style are discovered by discussion of present interactions with significant others and daydreams and yearnings. It usually becomes clear that it is very important for the student to maintain control over his/her environment and over the relationships he/she has with others. The tolerance of anxiety is very poor and much of what he/she is trying to do is avoid feeling worried or unsettled or anxious about the opinions of others. There is an extreme fear of failure and the need to stay away from any perceived shortcoming will result in their struggling hard to keep ahead and running away from failure rather than pursuing success. The consequences of this can be pointed out and have been usually experienced by the individual. One is the empty hollow sensation they feel after they have achieved success. They often experience a sense of let down, after they have met a goal of completed a project, because all it means is another hurdle has been lept and has kept them from failing. This often translates into promotion or achievement depressions. In addition because of the need to maintain control and to be competent it is very difficult for them to ask for help. This can be illuminated, by exploring why they don't readily ask others for help and why they feel that it is somehow wrong or imposing on others as compared to how they feel when others ask them for help. It becomes clear that their logic circuitry doesn't make their asking the same as when others ask them. This again usually leads back rather quickly to the reason they feel unjustified in asking the help of others, namely that they don't feel they deserve it, or thac it would be admitting to a deficiency.

Another important aspect of the intervention is to help connect thoughts and feelings. The student usually lives in a world of thoughts dominated by the internal dialogue between conflicting possibilities and constant rehashing of past and present experiences and anticipating future ones. They debate what to do or not to do and there is little internal monitoring of what they feel. When one asks, "how did that make you feel?" often the response is usually, "I thought this" or "I thought that." There is really no apparent appreciation of the difference between what one thinks and what one feels. So a major goal is to connect feeling and thought and to help explore the possibility that feelings are important in ones psychological life, that indeed they are often more important as motivations and as influences than are thoughts. One of the defensive purposes, of course, of obsessive-compulsive operations is to disconnect and protect oneself from any feelings. If one is attempting to be logical, reasonable, and right one doesn't want to be confused by such illogical, irrational things as feelings. By gently encouraging the student to look at how they felt in various situations and at various times when they were thinking whatever they were, the student usually develops a clearer understanding that they do have feelings and that they are important. Again the consequences of the split between these two phenomena are explored. This usually occurs in the context of how the split affects their relationship with other people. They become able to see that they are often perceived by others as aloof, uncaring, cold, distant,

and unfeeling. They realize that this often has been a detriment to them. On the other hand, they realize that by being able to cut themselves off, they can be calm and cool and collected in situations where others are not. As With the other pattern and functionings one isn't trying to stress only the negative consequences but to remain netural and examine the consequences in their totality. This allows the student to feel that there is no set way they are expected to behave or operate and they will be free to choose what they will change and what they won't. The important principle is that the therapist stress understanding the processes and the recognition of what results from them.

INTERVENTIONS

At each session the student is allowed to begin where he/she wishes. Attention is given to new developments in the student's life, new thoughts about him/herself and whatever else has occured in the interval between meetings. The therapist, however, constantly maintains an internal set that keeps the focus of the brief treatment central and at some point if the discussion hasn't spontaneously arrived at the agreed on areas, it is brought there.

If the assessment has been correct, there is usually fresh material reflecting the obsessive-compulsive style and which again can be pointed out. If the capacity for insight and self-learning is there, the student usually begins to recognize the patterns.

Example One:

At both the 2nd and 3rd session, Ted would in the 2nd 10 minutes of the hour, give a run down of his physical health status; his stomach had begun to hurt occasionally, he worried that something was wrong.

THERAPIST: "What could it be perhaps?"

TED: "Oh I don't know, just upset probably."

THERAPIST: "Whatelse comes to mind?"

TED: "Oh," pause, "The thing I really worry about is that it's cancer."

THERAPIST: "Then what would happen?"

TED: "I couldn't do anything about it, (control) it would get me."

later. . .

TED: "I was dizzy while I was trying to study. I started thinking about it."

THERAPIST: "What did you think?"

TED: "That they had missed something, that it was cancer and..."

THERAPIST: "And what?"

TED: "That I'd go crazy, or not be able to think, and not get into Law School."

The primary goals remain the same; to examine the style, its cognitive aspects, affective aspects and the behavior into which they translate and to understand their purposes, and their consequences.

It seems that because of the therapists positive regard for the student, his/her acceptance, and sharing of the burden, permission is granted for the student to begin to modify and relax his/her self-demands. By gently querrying as to how and when these patterns began, some of the attention is given to connecting the present with the past. With this prompting and neutral questioning, very often significant material comes up.

Example Two:

In the 4th hour George began discussing his sense of inferiority in relation to the other students in his math class. He worried that he wasn't as smart as they.

THERAPIST: "How does it show up?"

GEORGE: "I don't guess it really does, it's just that I worry about it. I get nervous that I won't understand what he's (teacher) talking about... that something is wrong with me."

THERAPIST: "Have you always thought this way?"

GEORGE: "You mean in class?"

THERAPIST: "That, but in general too."

GEORGE: "I don't know. As long as I can remember, at least since Junior High."

THERAPIST: "What have you thought could be wrong with you?"

GEORGE: "That I had brain damage, that I had lost some of my ability." Pause.

THERAPIST: "Had lost them?"

GEORGE: "Yea, I've never told anyone but, I've always wondered if I had brain damage. When I was five, I almost drown at the lake. Allen (his older brother) saved me and I was out for awhile. I've always wondered if I have any damage because of lack of oxygen."

He then went on to report the event in more detail and his relationship with his brother who he admired and envied. Both were very meaningful to him.

The student can be helped to see that ideas, self-perception, and events of earlier years whcih may influence his/her present often were done with cognitive and emotional equipment which may have been immature and therefore unable to accurately evaluate what was reality and what wasn't and to have proper perspective of the events.

Example Three:

> In the course of discussing Ted's emphasis on doing well in school he reported that his mother had been his 2nd grade teacher. He had felt at the time confused as to when she was his mother and when his teacher; he had believed that she didn't think he was doing well because of her comments both at school and at home. He had always felt that it was necessary to do well to avoid her criticism, both at that age and possibly since. It seemed that this imperative had become autonomous, and was functioning in the present although as an adult he didn't now believe that her love was really contingent on his performance.

Now, as young adults, the students have a second chance. They are able to re-examine their self-assumptions and correct distortions and misconceptions. In William James' term they can be "re-born".

The intellectual awareness of the obsessive-compulsive style and its ramifications is easier to reach than its emotional knowledge. This takes more time and new experiences. When it occurs, it can be quite moving.

Example Four:

> George while consoling his wife after she had received a B instead of an A in one of her courses, was telling her that she shouldn't expect so much of herself. She was working full-time and taking 2 courses, a B was very good under the circumstances and that what he thought of her didn't depend on her grades. She had unrealistic expectations of herself. Then it hit him. This was exactly how he thought himself; he had the same emphasis for the same reasons. What he had been talking about in our sessions really hit home.

I often point out that by changing ones course at sea by only a few degrees, your eventual destination will be greatly effected. This of course is to say that recognition and redirection of even small behaviors and attitudes can eventually have significant impact.

At the half way mark I begin to discuss the pending termination. I inquire about the student's reactions, thoughts and feelings. In most cases there is ambivalence. On the one hand it has been helpful and they are ready to be independent. On the other are the dependence striving and the fear of not being able to make it alone. They are examined and worked through as much as possible. Termination comes for the majority as scheduled.

CASE I
PART II

At the end of the first hour an assessment summary was presented to George. It was suggested that George had a way of thinking and behaving that put great stress on being as good as possible; that he was really trying to be perfect. This in turn seemed connected to his self-system. To like himself he had to be flawless, he had to be esteemed by others. Why was this so? Perhaps we could look into it.

The pressures of school, the pressures of his habitual ways of interacting with other and of thinking had not only made him feel psychologically bad, but had physical expression too. A treatment plan of seven weekly sessions focusing on the above phenomenon was offered and accepted.

George rapidly developed a self-reflective habit. He recognized his patterns and he could report his self-perceptions. He shared with me a great deal of his developmental history about which he was ashamed or embarrassed. He had been exposed to an almost organized regimen of depreciation and conditional acceptance by his stepfather. None of his reactions and fantasies had been shared with anyone before. Both he and I could see how he had arrived at his self-perceptions. He recognized how he limited himself in interactions with others, especially women. The focus remained the same, recognizing, seeing what was there, working it through, exploring it, trying to make sense of it, then coming to peace with it if possible.

He began experiencing fewer and less frequent anxiety episodes and could usually connect them to a stimulus in his life which in turn usually had to do with performance either

socially or academically. He became optimistic about the future, he voiced the thought with conviction, that it wasn't who you were, or how well you did that made you worth something. He approached and began to date a woman he had here-to-fore loved from afar. He continued to work hard and feel that it was important to do well, but with less pressure and with awareness of why he felt this way.

Termination was dicussed, beginning at the end of the 4th hour. He was ambivalent about it. He would prefer to continue but thought it was related to wanting someone who "understood". Termination came as scheduled. He had occational moments of the "blues", but no extremes and no panic attacks.

CASE II
PART II

As in the first case, at the end of the evaluating session, a summary was offered. In essence, it was pointed out to Ted, that he seemed to be under a great deal of stress. Even though his psyche didn't register it, his soma did. Control of both himself and his environment were important, as were achieving success, even at a great cost.

There was a split between what he felt and what he thought, with more of the latter than former. His self-esteem, and self-image seemed to be a big question mark for him. It was suggested that he and I meet together once a week for seven weeks and work on recognizing and identifying what was going on in his life and in him; that we try to understand it, what it was this way, what consequences for him it may have, and finally perhaps other solutions, or alternatives would develop. We would plan to terminate at the end of the seventh session, but remember to talk

about termination somewhere near the middle of out time together. Ted readily agreed to this plan.

Over the course of the seven sessions through discussion of his current circumstances, his fantasies, and daydreams about himself and his future, it quickly became apparent to Ted and me how much he was bound up in all his activities by the sole purpose of maintaining his self-esteem and his image as a big achiever. He reflected and remembered how in the 7th grade, when 13 years old, that he discovered the "magic" formula" that if you just worked harder and longer than anyone else you could beat them; you could be "number one". His headaches and dizziness decreased and disappeared. The ominous fourboding was gone.

He decided to cut back on hours at work and he decided on a course of action for after graduation that was based on his own interests and desires and less on what he thought others would think of it. He began to recognize and understand his routine thought processes and the consequences of them.

At the 5th session, the approaching end was brought up. He reported having thoughts about it occasionally. He felt that it was nice to have someone to talk to and he felt he had been helped, but it also would be good to try it on his own. As termination came, he was resolved to going it alone, and although aware of his dependency feeling they were not dominant. He happily reported that he had not had any "cancer signs" for awhile, and although he knew it would take more time for him to work out his ways, at least he could recognize them.

SUMMARY

This paper has tried to present one technique and rationale for helping individuals with obsessive-compuslive patterns, who have a low baseline self-evaluation. The therapeutic attempt is made to examine present behavior, thoughts, and feelings in the context of the person's self-perception, especially self-image and self-esteem.

Stress is placed on an analysis of the consequences of habitual modes of cognition, behavior, and affective reaction. It represents a blending of Mann's time-limited technique, insights from the exploration of the narcissitic aspects of personality, the cognitive therapy approach and psycho-dynamic treatment.

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